

EXHIBIT B

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization/Division of Epidemiology

Immunization Requirements for School Attendance Medical Exemption Statement for Children 0-18 Years of Age

NOTE: THIS EXEMPTION FORM APPLIES ONLY TO IMMUNIZATIONS REQUIRED FOR SCHOOL ATTENDANCE

Instructions:

1. Complete information (name, DOB etc.).
2. Indicate which vaccine(s) the medical exemption is referring to.
3. Complete contraindication/precaution information.
4. Complete date exemption ends, if applicable.
5. Complete medical provider information. Retain copy for file. Return original to facility or person requesting form.

1. Patient's Name _____
 2. Patient's Date of Birth _____
 3. Patient's Address _____
 4. Name of Educational Institution _____

Guidance for medical exemptions for vaccination can be obtained from the contraindications, indications, and precautions described in the vaccine manufacturers' package insert and by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) available in the Centers for Disease Control and Prevention publication, Guide to Vaccine Contraindications and Precautions. This guide can be found at the following website: <http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm>.

Please indicate which vaccine(s) the medical exemption is referring to:

- | | |
|--|--|
| <input checked="" type="checkbox"/> Haemophilus Influenzae type b (Hib) | <input checked="" type="checkbox"/> Measles, Mumps, and Rubella (MMR) |
| <input checked="" type="checkbox"/> Polio (IPV or OPV) | <input checked="" type="checkbox"/> Varicella (Chickenpox) |
| <input checked="" type="checkbox"/> Hepatitis B (Hep B) | <input checked="" type="checkbox"/> Pneumococcal Conjugate Vaccine (PCV) |
| <input checked="" type="checkbox"/> Tetanus, Diphtheria, Pertussis (DTaP, DTP, Tdap) | <input checked="" type="checkbox"/> Meningococcal Vaccine (MenACWY) |

Please describe the patient's contraindication(s)/precaution(s) here: Child has a severe autoimmune encephalopathy known as Hashimoto Encephalopathy. He experiences marked behavioral regressions with infection or vaccines. He is being treated with intermittent corticosteroid burst which are also a vaccine contraindication

Date exemption ends (if applicable)

Two years (9/1/2021)

A New York State licensed physician must complete this medical exemption statement and provide their information below:

Name (print) Rosario R. Trifiletti MD PhD NYS Medical License # 176660-1

Address 545 Island Road

Ramsey, NJ 07446

Telephone 201-236-3876

Signature _____

Date 8/29/2019

For Institution Use ONLY: Medical Exemption Status ☐ Accepted ☐ Not Accepted Date: _____